In-Depth Review

Mental Health and Employment Partnership (MHEP)

Social Impact Bond – produced as part of the CBO Fund Evaluation

Commissioning Better Outcomes Evaluation

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ATQ Consultants

ECORYS

01
Summary

Mental Health and Employment Partnership (MHEP) is a vehicle through which local commissioners of mental health supported employment services can procure a specialist intervention known as Individual Placement and Support (IPS). IPS is designed to address the employment support needs of people with severe mental health conditions, based on having an employment advisor embedded in local mental health professional teams.

At 1 April 2016, MHEP has supported the commissioning of three year IPS service contracts with three public bodies – Staffordshire County Council (Staffordshire), London Borough of Haringey (Haringey) and Tower Hamlets Clinical Commissioning Group (Tower Hamlets).

The value of outcome payments to the service providers is up to £2.9m based on the achievement of employment outcomes for up to 2,800 service users.

The direct costs of designing the SIB were £150k, which was the cost of the grant Social Finance received from the CBO Fund. Other costs borne by stakeholders were not deemed to be above and beyond the normal cost of commissioning a new service.

Strengths and advantages

MHEP provides a ready to use service specification and contract that it is flexible enough to accommodate different contractual arrangements according to commissioner's respective requirements.

MHEP and social investment backing has provided **the basis for stable funding** for continuation of IPS services.

It has also allowed for **increased scale** of IPS delivery and evidence sets.

Higher levels of scrutiny mean the drive for improved performance is stronger.

Commissioning and bidding costs were not significantly different to normal – "***SIBS are different not difficult***"

Open book philosophy creates **levels of trust** that allow for risks to be taken.

Challenges

Providers have found that the MHEP contract management team have been **going up their own learning curve** which has required support from limited senior management resources.

Providers **do not yet fully understand** all the detail of the MHEP special purpose vehicle and its financial and operational arrangements.

Providers have been given **different targets** by the MHEP contract management team and Centre for Mental Health which provides IPS accreditation and this has caused some operational issues.

The need for **multiple reporting lines** has added a layer of administrative burden on providers.

Lessons

The time taken in the MHEP development process turned out to be a '**proving process**' that created a quality set of support information and materials that helped commissioners gain buy-in from their internal colleagues.

Similar to other SIB developments, a key pre-requisite is for commissioners to have **an openness to working with what is perceived as an innovative commissioning approach**.

Any perceived innovative approach requires **clear communication** to support the continuous 'sell' internally. Clear communication also helps to **ensure that interests remain aligned** as issues and challenges arise, particularly where there are co-commissioners.

Setting up further co-commissioner interest and a relationship remains hard to achieve. **Co-commissioning works best where there is a history of joint-working** already in place with clear decision authority and lines of accountability.

A **clear definition and understanding of outcomes** is required from all parties. Although use of outcomes and their measurement is increasingly normal, care has to be taken with the language as the same words can have different meanings in different settings e.g. health and employment outcomes.

Finally, based on providers' experience, a '**ramp up stage**' could be formally included in the outcome targets for volumes etc. as it takes time to build up all the relationships needed to deliver the IPS service.

02
What is the MHEP social investment model and intervention?

MHEP social investment model is one of a number of vehicles through which local commissioners of mental health supported employment services can procure a specialist intervention known as Individual Placement and Support (IPS). Social investment intermediary Social Finance designed and developed the model.

The IPS intervention is designed to address the employment support needs of secondary health service users with severe mental health conditions. The IPS service delivery model is based on having an employment advisor embedded in local mental health professional teams – truly a part of the therapeutic model – where employment is seen as a key step towards improving the wellbeing of patients.

The IPS employment advisor is involved in case discussions and offers a personalised / bespoke employment support service to the patient built around their wishes and needs. Once a placement has been made, support is provided to both the new employer and the employee to ensure sustainment, help with any adaptations and build up mutual confidence between all parties.

Social Finance has established Health and Employment Partnerships (HEP) as a separate company that is intended to establish - over time - different social investment vehicles of which MHEP is the first. MHEP was established as a special purpose vehicle (SPV) with an initial investment of £400,000 from Big Issue Invest (BII), which retains 100% of the economic interest in the company. HEP has a subsidiary interest in MHEP which confers some voting rights and a seat on its Board.

At 1 April 2016, MHEP has supported the commissioning of IPS services with **three public bodies**:

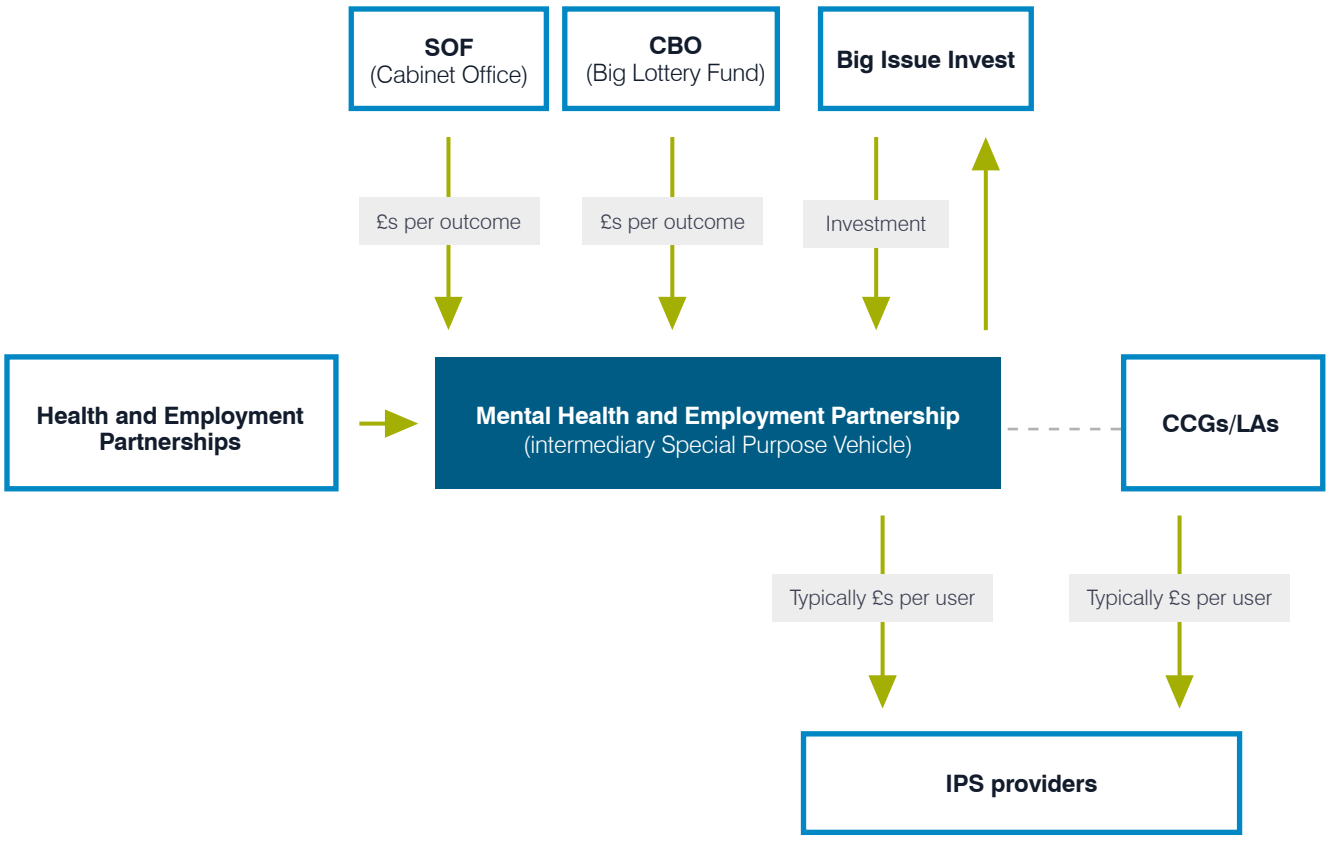
- **Staffordshire County Council** (Staffordshire),
- **London Borough of Haringey** (Haringey)
- **Tower Hamlets Clinical Commissioning Group** (Tower Hamlets).

Contracts will run for up to three years from 1 April 2016.

Both the Cabinet Office Social Outcomes Fund (SOF) and the CBO Fund have agreed separately to contribute towards outcome payments linked to successfully sustained employment for up to 2,800 service users across all three commissioner areas to 2019.

The structure of HEP, MHEP and its relationships with SOF and CBO Fund and BII as well as public body commissioners are shown in Figure 1 overleaf.

Figure 1: **Mental Health and Employment SIB Structure**



BII's initial £400,000 investment is partly in the form of equity (i.e. a direct stake in the MHEP vehicle) and a loan repayable at an interest rate of 8%. The equity investment means that BII has the full economic interest in the MHEP vehicle, and effectively owns the entity. Whilst HEP has subordinate economic interest in MHEP itself it is entitled to a performance bonus should certain targets be exceeded by MHEP. This is via a performance carry arrangement.

MHEP appointed Social Finance as its contract management provider.

MHEP is assuming the risk that the outcome payments to be made by SOF and CBO Fund are achieved.

The total potential outcome payments for the three contracts let to date is estimated to be +/- £2.9m.

Of these:

- SOF will pay up to £990,000 over the first two years of the contract
- CBO will pay up to £336,111 in year three at a slightly lower tariff rate
- Staffordshire will pay up to £674,240
- Tower Hamlets up to £736,960
- Haringey up to £180,000

The outcome payment model and indicative amounts payable are shown in Table 1 below.

Table 1: **IPS Outcomes and Indicative Payments**

	Successful engagement of users	**Job entry outcome** (<16 hours/week)	**Job entry outcome** (>16 hours/week)	**Job sustainment outcome** (<16 hoursweek)	**Job sustainment outcome** (>16 hours/week)
Outcome payment	£790 - £1,000	£700	£1,350	£1,400	£1,650
Paid by	MHEP/BII - 20% Commissioner - 70% SOF/CBO Fund - 10%	SOF/CBO Fund – 100%	SOF/CBO Fund – 100%	SOF/CBO Fund – 100%	SOF/CBO Fund – 100%

The rationale for the local commissioners making the successful engagement outcome payments is that they are benefiting from the improved health outcomes for patients. This benefit comes from their engaging with the IPS programme as part of their mental health treatment and the benefits from this accrues to the local commissioner.

Some local commissioners are contributing to job outcome payments as well but these are predominantly funded by SOF/CBO.

The rationale for SOF to pay for the employment outcomes is that its contribution reflects the savings to central Government from sustained employment and, in this context, SOF have agreed to act as a proxy for central Government whilst the IPS service model proves itself at scale with the help of the MHEP model.

The rationale for CBO Fund supporting this model is the strong potential for social impact on service users, for engagement with local providers through a variety of VCSE focused procurement models and for scaling, replication and generating impactful learning.

03
History of MHEP development and timetable

This section describes the steps taken from inception to contract delivery go-live over the 21 months from summer 2014 to April 2016.

Based on our analysis of SIB development projects in other areas, the length of time taken was not markedly different although, clearly, each SIB has its own unique characteristics.

Whilst it took some time at the start to gain formal commissioner interest, the social investor engagement and formal procurement processes appeared to benefit from the work put into the initial stages and were relatively quick and straightforward by comparison.

Quarter 2/3 2014

Social Finance was engaged in discussions with various parts of central and local government including the Department for Work and Pensions (DWP) about potential new areas where the application of social investment might be appropriate. DWP was itself interested in reviewing potential interventions for the 'hardest to help' referrals in the Work Programme and, particularly, those with health and mental health conditions.

> Though there is widely accepted evidence of the benefits of employment on both physical and mental health conditions, the outcomes for patients with mental health conditions were only marginally improved despite the availability of the Work Programme. In effect, there was a perceived 'gap' in service provision for this cohort.

This thinking led to an expression of interest to the CBO/SOF by DWP. Only local commissioners and agents working with them were eligible for CBO development grant funding, so DWP appointed Social Finance to engage with commissioners, including local commissioners and to research the feasibility of using social investment to support a specialised mental health employment intervention. A development grant of £150,000 was awarded to Social Finance for this work.

In researching possible interventions, Social Finance found that only one, IPS, had a significant body of evidence as to its effectiveness in supporting patients with mental health conditions into sustained employment. Social Finance found that there were (at that point) 22 randomized control trials whose results showed approximately twice the success rate for IPS when compared to other programmes/interventions e.g. Work Programme or no interventions.

Quarter 4 2014

Based on this evidence, Social Finance approached both central Government (DWP, Cabinet Office) and the NHS to find commissioning interest. NHS England, in particular, was keen on the idea and helped promote it to local CCG commissioners, Mental Health Trusts (MHTs) and other health bodies. Social Finance was also able to engage with many local authority (LA) commissioners given the overlap or potential joint funding from health or LA sources.

Despite its initial interest, at that point in time (late 2014), DWP was not in a position to commission an IPS service centrally or through its innovation funds and so the focus for seeking commissioners has remained on local health and government organisations.[1]

1. It should be noted (as at October 2016) that, as employment is now also a formal health 'outcome', DWP and NHS England have both earmarked funding to provide employment support services for mental health patients. NHS England has announced £50m budget and any DWP funding would increase this further. Exactly how this will be deployed by employment and health service public bodies remains to be confirmed.

> Despite high levels of initial interest from different health and local government bodies, there were frustrating challenges in gaining solid commitment that would allow the project to apply to SOF/CBO Fund for a contribution towards the outcomes payments.

In response to this difficulty, Social Finance conceived the HEP and MHEP vehicles as a way of enabling local commissioners and SOF/CBO Fund to jointly commission IPS services. This created a further challenge as the proposed HEP and MHEP vehicles created issues around their appropriate respective structures, governance and role of Social Finance that were resolved only at the end of Q3 2015.

Quarter 1 2015

SOF and CBO Fund were interested in what they saw as an effective service addressing the needs of some of the most vulnerable in society. SOF, in particular, was interested in seeing IPS proven in the UK context which, if successful, would provide the basis for much wider commissioning in the future.
Social Finance submitted a full SOF/CBO Fund application and, following its evaluation process, SOF approved up to just under £1m of co-payment funding in March 2015. This positive commitment by SOF proved to be key in helping reach agreement with other local commissioners over the next two quarters.

The application evaluation process for CBO Fund ran to a different timetable and its decision at the March 2015 panel (CBO Fund has a panel of external appointees that decides on awards) was deferred until Social Finance secured agreement from the local commissioning partners it was in discussions with and the final resolution of the MHEP structure referred to above. CBO Fund approved in principle in October 2015 and gave final approval in January 2016 to up to £336,111 of outcome payments.

Quarter 2/3 2015

Social Finance engaged with social investors and between July and October 2015 secured £400k of capital investment in MHEP from BII. This investment will fund MHEP's contribution to the initial engagement payments (20%) and provide working capital until outcome payments are generated.

BII found the MHEP investment proposition was unusual in the amount of research and development work that had been undertaken before and through the CBO development grant award. As BII does not have extensive resources itself, it relies on such evidence of the effectiveness of interventions to support its investment evaluation 'due diligence'.

Partly because of the work already done, the decision process for BII was a relatively short four-month period from end to end. Although there were other social investors reviewing the MHEP opportunity at the same time, BII found the proposal attractive, became 'keen' and was in a position to make a rapid investment committee decision. Originally BII had an insurer QBE as a potential co-investor but QBE's approval process length was such that they had to fall out of the process.

BII could have completed sooner than four months but their new fund was closing at the same time and it needed to wait for this, but only by a matter of weeks.

During this period, Social Finance was also able to conclude MHEP's respective Memorandum of Understanding agreements with Staffordshire and Tower Hamlets as two co-commissioners. London Borough of Haringey signed up subsequently.

Quarter 4 2015

Staffordshire and Tower Hamlets began their procurement processes. Haringey was different in that it had already been to market and procured an IPS service and subsequently moved this contract under the MHEP umbrella from January 2016 onwards. Negotiations with Haringey were concluded in three months between October 2015 and the end of the year.

Q1 2016

Evaluation of provider bids and awarding of IPS provider contracts was completed jointly by MHEP and the respective commissioning authorities. MHEP's role included supporting commissioners with the Invitation to Tender (ITT), specification of the IPS service, outcome definitions and outcome payment structures. Each commissioner ran its own selection process and awarded the contracts to the successful providers. MHEP had representation on respective selection panels, given that its financial health depends on the outcomes being delivered, and was comfortable with the selected providers.

Contracts went live on 1 April 2016.

04
Different contracting models at local level

The MHEP vehicle has been designed to allow for different commissioners to work with it in contracting with providers on an individual basis. This has allowed, for example, the structures for Staffordshire and Tower Hamlets to be different from each other whilst commissioning the same IPS service from respective providers.

4.1 Staffordshire County Council

Staffordshire had reviewed mental health employment support services in the County and decided to specify IPS back in 2010 when it commissioned the service provider Making Space on a block contract for five years.

This was by no means a straightforward process as there were several vested interests whose positions were threatened by the potential change. However, the challenge from these meant that, in order to make a robust case for the change to IPS, the commissioning team had to engage fully with users and use co-production techniques to design the new service.

This also focused the team on user 'outcomes' which, of course, was essential for the current MHEP outcomes-based payment contract.

The experience of Staffordshire in letting and running its IPS contract between 2010 and 2015 had demonstrated that IPS works best if its objectives align well with the respective mental health teams with which it is working. Employment outcomes became formally measured outcomes for Mental Health Trusts in 2013, which helped to boost performance especially in the 2014 – 2015 financial year. This also helped sustain the alignment of approach between the MHT teams and the provider through to the new contract.

Because the contract had been a success Staffordshire was looking at options for re-letting the service during 2015. At the same time the wider Authority was also interested in the potential for using social investment and this confluence of interests led to engagement with Social Finance and the eventual agreement to work with MHEP.

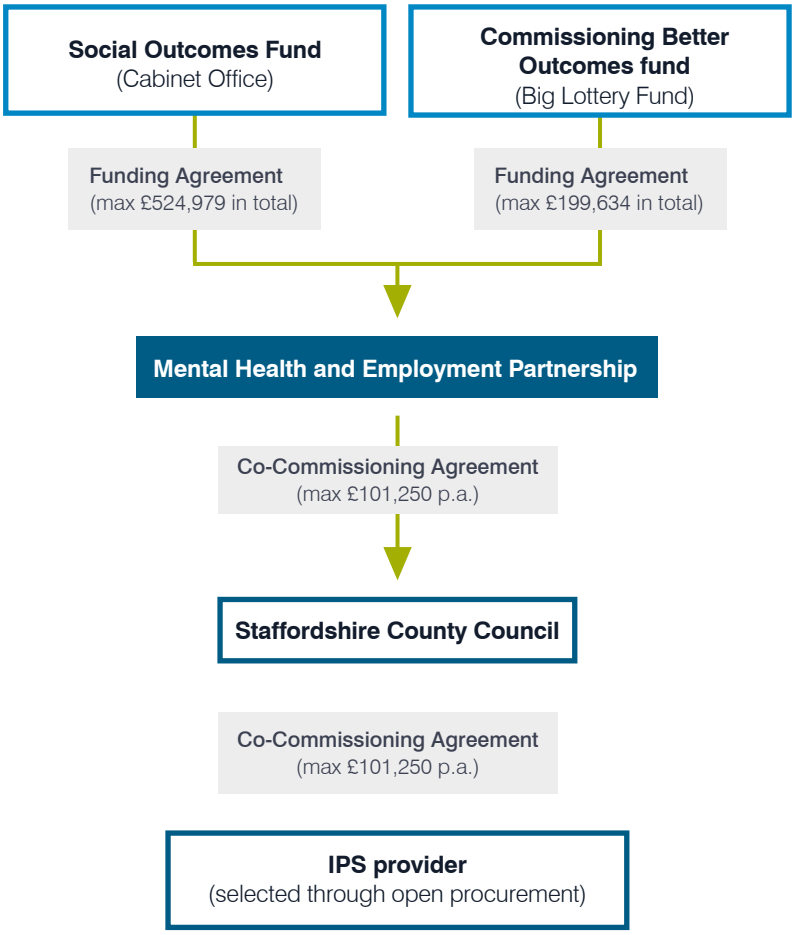
> Use of social investment therefore became an easier decision to make as a way of maintaining service provision when budgets were otherwise falling.

Staffordshire already thoroughly understood the outcomes and delivery model and so how it got funded was the decision point. In this respect, it certainly helped that co-payment from SOF and CBO Fund was available to enable a larger scale of provision than otherwise.

Staffordshire has reviewed social investment and finds the risk mitigation whereby financiers assume some or all of the risk of outcome payments as an attractive model.

Figure 2 overleaf shows the structure and financial flows for Staffordshire.

Figure 2: **Mental health/employment SIB commissioning model Staffordshire (3-year contract)**



Note: SOF/CBO funding for each area based on current view if likely referrals - the actual split may vary in practice (subject to agreed maximums)

The Staffordshire ITT specified the number of outcomes expected by type and the payment for each and invited bidders to offer discounts against these. There is an upside for outperformance that allows the full undiscounted rates to be paid in the end.

Following the open procurement process Staffordshire contracted again with Making Space (the new contract length is three years plus an option to extend for a year in line with the funding that is available for three years and the hope of further financing emerging between times to cover year four).

There is a Funding Agreement between Staffordshire and MHEP that defines who pays for which outcomes. This Agreement contains all the usual contract provisions that Staffordshire would have in any of its contracts with a counterparty. In this case, Staffordshire is paying for paid employment and jobs sustained outcomes and MHEP is paying a proportion of the attachment fee.

Making Space has only one contract to work to as before and invoices Staffordshire which pays and then, in turn, invoices MHEP for its proportion of the payments. MHEP has its own validation and checking processes.

Finally, there is also a Co-Commissioning Protocol between MHEP and Staffordshire that covers the performance management tasks that MHEP delivers as part of its services.

4.2 Tower Hamlets CCG

Tower Hamlets also had a contract due to be re-let in time for 1 April 2016 for provision of supported employment services, which led to its engagement with Social Finance.

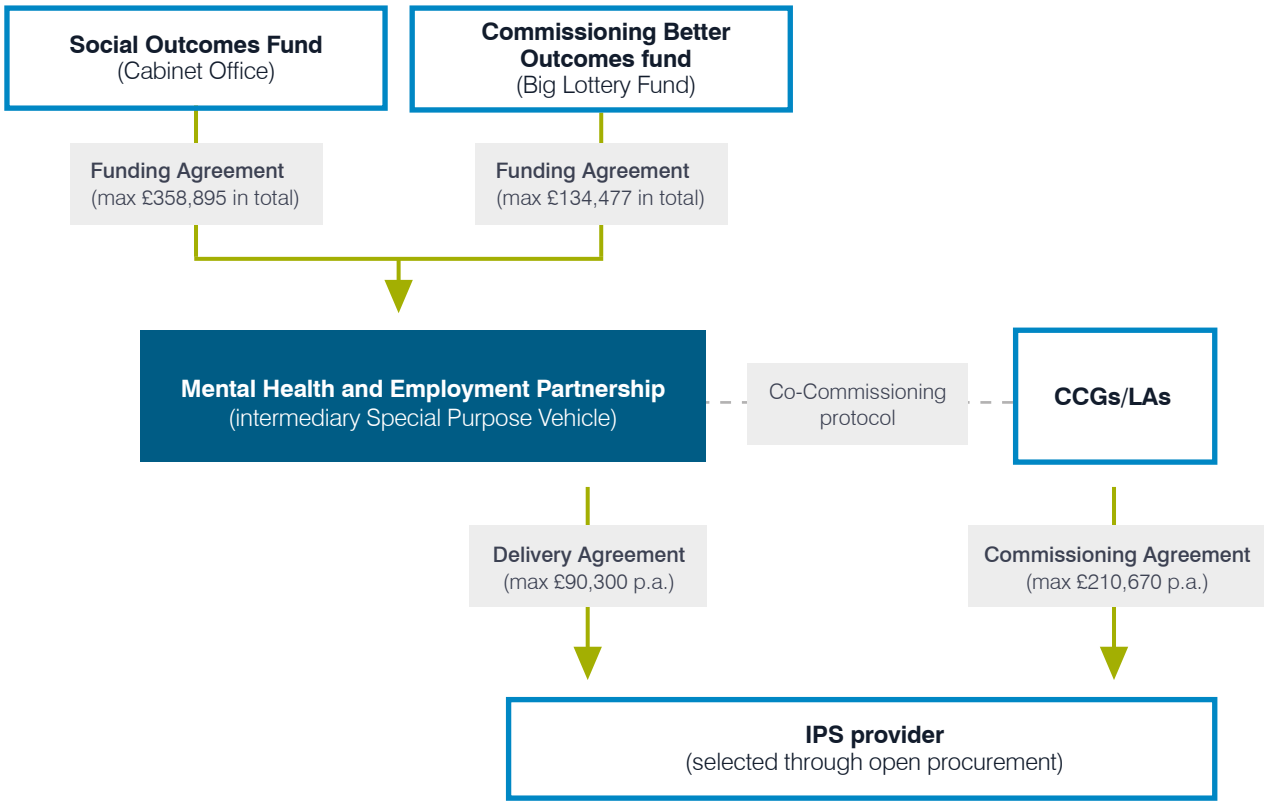
In Tower Hamlets' case, the previous delivery model was not IPS although it did use a similar embedded worker model, so the precedent for working within the local mental health team was already established. The structure and financial flows for the Tower Hamlets' model is shown in Figure 3 below.

Tower Hamlets was interested in moving towards use of outcomes and payments linked to outcomes to help drive improved provider performance. Its underlying approach is to use outcomes payments as a carrot rather than as a stick or means of "punishing" providers.

The contract was block funded for the first six months to help get the new IPS service off the ground and moved to outcomes payments from then on. MHEP provided the ready-made outcome structure and payments model which is based on each customer engagement with fixed payment amounts according to separate outcomes. These are the same for all funders i.e. CBO Fund, SOF and Tower Hamlets are all paying the same percentage of outcome split as each other.

Invoicing arrangements are different to Staffordshire. Both MHEP and Tower Hamlets pay providers directly for outcomes. There is an MoU between Tower Hamlets and MHEP that covers this aspect. Technically the provider has two contracts – one each with MHEP and Tower Hamlets. In practice the specification is identical so from the provider perspective it is working to a single contract.

Figure 3: **Tower Hamlets Structure and Financial Flows**



Note: SOF/CBO funding for each area based on current view if likely referrals - the actual split may vary in practice (subject to agreed maximums)

The provider produces one set of contract management data. There is a higher level of contract scrutiny linked to the social investment involvement. MHEP has been providing pro-active support to the provider to help it produce the MI and with supporting systems.

4.3 Haringey

At the start of 2015, Haringey reviewed its mental health services and commissioning approach and looked at IPS in this process. Haringey liked the embedded personnel delivery model and also the fact that IPS had a solid evidence base.

Haringey identified a budget of £180k over two years from its own Public Health and Adult Social Care budgets, supplemented by a local Jobcentre Plus grant and some funding from the CCG. This demonstrated that it was open to co-commissioning as a means of finding additional monies.

The commissioning process received internal approval in May 2015 and was run to a short timetable in June 2015. The appointed new provider, Twining, began delivery from 1 July 2015. The original payment model was for Year 1 to be paid in advance to the value of £90k and for Year 2 to be paid based on activity and outcomes only. In Year 2 there was some payment on successful engagement (after referral) but in the main payments were linked to employment outcomes.

In August 2015, Social Finance approached Haringey to find out more about the IPS service that had been commissioned. This discussion led to Haringey entering formal negotiations to join the MHEP programme, which would provide an additional £90k of funding i.e. a further year's equivalent budget.

Agreement between Haringey and MHEP was reached in October 2015. **Haringey moved from first contract discussions to go live in three months (October 2015 to January 2016) which shows how quickly negotiations can move if the conditions are right.** This was clearly made easier by the fact that Haringey had an existing provider contract in place that it only had to move into the MHEP vehicle.

There is now a commissioning agreement and protocol between Haringey and MHEP. The provider, Twining, was formally engaged by MHEP as a provider of the IPS service. MHEP is jointly contract managing Twining with Haringey from financial, quality and safeguarding perspectives.

Since moving the contract under the MHEP umbrella, the outcome payments are all linked to the IPS standard performance reporting models rather than anything developed by or with Haringey.

> From Haringey's perspective, there was little challenge in agreeing to move its contract into the MHEP model given that this brought further funding that allowed the Twining team size to expand by an extra person.

05
Strengths/advantages

5.1 Flexibility of MHEP structure

One of the advantages of the MHEP structure is that it is flexible enough to run different arrangements in each location i.e. Tower Hamlets, Staffordshire and Haringey.

MHEP has been designed so that it can readily be used by other commissioners in the future. There is a ready-made ITT specification and outcomes payments structure for an IPS service, as well as a performance management infrastructure, in place.

The design of the MHEP vehicle is deliberately open to adding further commissioners over time as new outcome payment budgets become earmarked or made available, for example, from NHS England or DWP.

5.2 Stable funding for IPS services

MHEP has allowed public sector organisations to carry on with commissioning Voluntary, Community and Social Enterprise (VCSE) providers of IPS services where there would otherwise have been cuts in budgets and scale of delivery.

The VCSE providers awarded contracts under MHEP had been delivering IPS services but had faced uncertain budgets and changes to budget levels mid-contract as well as increasingly shorter contract lengths. In contrast, the SIB model guaranteed them a set level of funding for three years.

In all previous IPS service delivery contracts, providers experienced what they termed 'over-subscription' of their services. The Staffordshire team noted that MHEP and use of outcomes payments allows for the service to be fully funded (depending on performance) whereas the previous programme was always facing funding challenges.

5.3 Ability to scale

The initial support from CBO Fund and SOF to outcome payment values means that delivery can be made at a scale far larger than previously envisaged by the three commissioners and this will provide a more significant UK-based evidence set for other commissioners as to the impact and effectiveness of IPS as an intervention. This is an indirect benefit of the SIB approach, however, since it is by definition a result of the CBO Fund and SOF contribution, rather than the use of a SIB model per se.

The advantage of MHEP is that it has allowed the team sizes to expand and also freed up managers from front line duties so that they manage more effectively and focus on innovations to the service model such as greater use of digital communications and social media.

> *"It is useful to work to a standard and it keeps us on our toes"*

5.4 Increased scrutiny may drive improved performance

All providers reported, even at this early stage in contract delivery, that outcomes and payments linked to outcomes has made a difference to their approach because of the frequency of review. One provider noted that in the block contract era, contracts were managed on an annual cycle and if, for example, performance was behind at the end of quarter three then managers would implement changes at that point to try and catch up against yearly targets. Under the MHEP contracts providers report formally on a quarterly basis with monthly updates and conference calls in between. Even though the IPS delivery model is not linear – providers are dealing with human beings with mental health conditions – the scrutiny adds a helpful 'pressure'.

Providers agree that issues are likely to be addressed more quickly because of the outcome payment imperative but they would address performance anyway for professional reasons.

It is "*useful to work to a standard*" and it "*keeps us on our toes*".

5.5 Streamlined commissioning processes

"*SIBs are different not difficult*." (Commissioner)

For Staffordshire, use of social investment and the need for the MHEP SPV was "different but not difficult". The main area of difference relates to the need to establish agreements between all of the counterparties. In Staffordshire's experience this worked relatively well and was neither that difficult nor added too much cost. There was some additional legal support needed because of the number of agreements between parties.

In other respects, the normal provider procurement competition processes were run with ITTs issued, responses scored and winners awarded contracts after the usual stand still periods. This does not appear to have caused significant challenges for either the commissioners or the providers. This is in contrast to the experience of some others who have developed SIBs and may reflect the flexible, structure of the MHEP model and approach, which means that each commissioner does not have to develop outcomes and payment structures from scratch. It may also be because the commissioners are already delivering the IPS intervention and therefore there has been less need for extensive research and service design.

> From Haringey's perspective, there was little challenge in agreeing to move its contract into the MHEP model given that this brought further funding that allowed the Twining team size to expand by an extra person.

The involvement of MHEP did not affect their bid - "*just a source of funding essentially*" - and so did not present an additional burden or require more head space or cost.

5.6 High levels of trust between parties

The 'open book' philosophy of MHEP is also seen as helpful by providers.

"*It allows for honest conversations about what is working and why and where service design can be altered or amended.*"

At present, all providers have experienced set up and local health team embedding issues (which are not unexpected as services are scaling up). One provider is absorbing a loss in the short term on a planned basis and is prepared to do so until the remedial steps in place now improve the situation.

The provider in question stated that it is "*comfortable with the balance of risk and opportunity.*" Part of the willingness comes from knowing that there is a good alignment of interests with the lead commissioner and this is crucial to help overcome the inevitable 'bumps in the road' during the life of a contract. Without this, the provider would be a lot more cautious.

06
Disadvantages

6.1 MHEP contract management learning curve

Providers reported that there has been a need to take the MHEP contract management team up a learning curve about how IPS works and the realities faced on the ground in different regions of the country.

> *[MHEP is making] endless information requests*
>
> Service provider

As part of this process, MHEP has made numerous additional data requests which in some cases have then led to further data requests which not all providers have the capacity to easily manipulate and provide.

6.2 Provider understanding of MHEP vehicle

Although none of the providers have any difficulty with the idea of the MHEP vehicle and its involvement, it is not totally clear to providers what all the details of the MHEP structure are and the relationships between the various parties – MHEP, Social Finance, BII et al.

6.3 Different targets from different 'masters'

Achieving IPS Centre of Excellence accreditation is a requirement of the contract which effectively means that providers are meeting a high standard of IPS service delivery. The Centre for Mental Health completes the assessment and has proven to be more flexible in its approach to how IPS is implemented in the light of on the ground realities in the MHEP team.

The challenge that has arisen from this is the difference between MHEP's targets and those that the Centre for Mental Health would recommend for achieving Centre of Excellence status. Specifically, MHEP has a higher successful engagement level target.

> Providers have two 'masters' with different expectations and this needs management's attention.

6.4 Multiple reporting lines for providers

One provider finds that it now has two management reporting lines and requirements to service and had found it more burdensome. Another provider identified three stakeholders to whom they now report: Local Authority and CCG commissioners; and Social Finance as MHEP contract manager who in turn report to BII as investor. **The multiplicity of stakeholder interests has added complexity.**

It took a while to get all parties to agree to a single report format and content and it took some negotiation to get to an agreement on this.

Providers have had to commit a greater resource to data collation and reporting than in previous contracts as a result.

07
Other observations

7.1 MHEP preparation of materials enabled commissioner buy-in

Although all the respective local commissioners had experience of IPS or an equivalent embedded employment support worker in mental health teams, their decision to re-commission IPS was made much easier by the availability of well-prepared presentations on evidence by the MHEP team.
This example of the kind of support to the commissioning process that MHEP made available was instrumental in getting the commissioning approval decisions over the line.

7.2 Communication is a key challenge

In Tower Hamlets' commissioning process experience, internal communication was a key challenge that needed constant attention so that the commissioning proposition is explained to stakeholders, particularly about the benefits, and that concerns about 'risks' are addressed.

In turn this means that:

- resources need to be dedicated to the communication task so that the new idea is 'sold' continuously;
- the commissioning organisation has to be receptive to new ideas and have the capacity and organisational capability to arrive at a decision and take it forward; and
- as with any innovation that takes time to work up, there is a risk at any stage in the development process that a 'bad news' story can derail the whole project.

7.3 Engaging co-commissioners remains challenging

Co-commissioning is not a challenge where a local authority and CCG co-funding agreement is already in place, as it is usual for one or the other to be allocated responsibility for commissioning activities. Conversely, when this arrangement is not in place, it will add to the timetable as interests have to become aligned and agreements reached.

In both Staffordshire and Haringey's cases, there was already joint funding between the Local Authority and the CCG for mental health services.

Tower Hamlets CCG by contrast could have engaged with the London Borough of Tower Hamlets as a co-commissioner but chose not to as they were already spending the budget and felt more comfortable keeping it under their own control. Involving the Council would have added complexity and it was felt that this would have introduced unnecessary risks to the timetable and potential delays.

7.4 Clarity of outcomes is required

Outcomes based commissioning has a different meaning for health commissioners and local authorities and so it is critical to be very clear on the language that is used. Providers suggest that getting report content agreed and clear up front would be an advantage in the future. Providers would recommend that the definitions of 'engagement', 'client', 'job entry', 'sustainment' etc. are all agreed by all commissioning parties before the contract starts.

Finally, agreeing on any exception scenarios to outcomes as defined i.e. someone falls out of one job but found another one, temporarily not working etc. would also be helpful.

7.5 Sequencing

One of the key challenges in SIB development lies in the sequencing and the amount of time it can take to line up the various stakeholders (gain buy-in) and decisions required. Commissioner team resources are key to making progress and this works best when there are also clear accountabilities and lines of reporting. The positive of the development process and the amount of effort needed to, for example, engage with potential co-commissioners is that it helps refine the proposition and intervention model. In effect, the idea is stress tested by a variety of commissioners and lessons drawn from the feedback help to shape the final proposition.

08
Lessons Learnt

1	The creation of MHEP and engagement with potential commissioners took over one year but the development process was a 'proving' process that led to a robust final design. It proved to be a time saver later on as the service model and the structures, etc. had all been 'stress tested' thoroughly in the development process.
2	As ever with gaining buy-in to a new proposition, finding a significant first party to sign up gives confidence to others to follow. The SOF fulfilled this role on this occasion.
3	Similar to other SIB developments, a key pre-requisite is for commissioners to have an openness to working with what is perceived as an innovative commissioning approach.
4	It is also key for values across organisations, such as co-commissioners, to be well aligned so that issues and challenges that arise are more readily addressed.
5	Given the usually lengthy timetable for SIB development, it is key to have a resourced communications role so that the proposition is continually 'sold' to stakeholders and that benefits and risks are understood.
6	Use of outcomes and their measurement is normal but care has to be used with the language as they can have different meanings in different settings e.g. health outcomes.
7	It is important that commissioning organisations have clear accountabilities and reporting lines so that approvals can be agreed on a timely basis.
8	Based on providers' experience, a 'ramp up stage' should be formally included in the outcome measures, targets for volumes etc. as it takes time to build up all the relationships needed to deliver the IPS (or other) service.
9	Strategic alignment and congruence across stakeholders helps as well. If these are set well then issues can be more readily overcome. As an example, in Staffordshire the CCGs have undertaken a clinical prioritisation process (CPAG score) for different outcomes and employment is now a high scoring outcome which means the CCG's commitment to funding the programme is as good as it can be.
10	Despite MHEP's best efforts to keep contract drafting as simple as possible by using standard legal Terms & Conditions for each area, CCGs have different accountabilities and responsibilities from LAs and so changes had to be incorporated to reflect these.

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Conclusions

IPS is an evidence based programme (EBP) service model which, although well-established outside the UK, is relatively new here. As noted earlier, the sound international evidence base about the effectiveness of IPS made the specification decision easier to arrive at for Staffordshire, Tower Hamlets and Haringey. It was also a positive for BII as evidence of how programme delivery has succeeded elsewhere is one of the due diligence question areas.

MHEP is acting as a 'pathfinder' to provide evidence for future commissioners as well as a 'ready to use' commissioning model in the UK.

MHEP is a further example of a social investment vehicle designed to allow for multiple commissioners to employ a particular service or intervention model.

What is new here is the MHEP vehicle itself and the way providers are financed and paid rather than the IPS service. The key area of difference from previous contract arrangements is the number of agreements that are required between the counterparties – HEP and MHEP, local commissioners and MHEP, MHEP and Social Finance as performance manager and all with BII, SOF and CBO Fund.

> The main difference that social investment has brought to the table is secure funding at scale, support to commissioners to continue working with VCSE service providers and a strong performance focus on outcomes. It has, however, added additional reporting lines and data requirements.

The evaluation will revisit MHEP half way through its delivery.

Key questions we will focus on at this stage will include:

- Has the availability of a ready to use service specification and contract enabled other commissioners to get involved in the SIB?
- How is the additional evidence being generated through the SIB being used, particularly amongst employment commissioners?
- Are the additional reporting and data requirements adding to, or detracting from, service delivery?

Mental Health and Employment Partnership (MHEP)

This In-Depth Review report is the third in a series being produced as part of CBO Fund Evaluation, commissioned by the Big Lottery Fund and undertaken by Ecorys UK and ATQ Consultants. The report was written by Edward Hickman, Director at ATQ (**Edward@atqconsultants.co.uk**). The CBO Fund aims to encourage the development of SIBs and similar financial mechanisms. The report is based on a review of documents provided by stakeholders and consultations with key stakeholders involved in the SIB, including representatives from the CCGs and LAs, Social Finance, BII, Centre for SIBs and the service providers. Consultations took place just as the intervention was beginning in mid-2016.

The report will be updated in subsequent years to provide an account of the SIB's progress. In total, the evaluation will produce In-Depth Reviews of ten SIBs part-funded through the CBO Fund. The others featured so far are Ways to Wellness (helping people in Newcastle with Long Term Conditions manage their illnesses) and Reconnections (tackling social isolation in Worcestershire).

The In-Depth reviews, and more information about the overall CBO Fund Evaluation can be found here:
www.biglotteryfund.org.uk/research/social-investment/publications.

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